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# Program Analysis of an Adult Sex Offender (ASO) Treatment Group

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## ABSTRACT

The research question that was examined in this research study is whether or not The Center for Child and Family Advocacy's adult male sex offender group is effective in lowering risk responsibility and criminality, and increasing treatment cooperation, self-management, and social ability and supports. The specific program material used in this treatment group is *The Road to Freedom*, by Morin and Levenson (2002). This experimental study utilized a paired-sample *t-test* to examine the differences between the first measurement and second measurement of three groups: current client, completed clients, and all clients.

The results demonstrated that this particular treatment program had statistically significant improvements between the total scores of first measurements and second measurements. This proves that the agency's program is effective overall. More specifically, it is effective in lowering risk responsibility and criminality, and increasing treatment cooperation and self-management. There is some limited support for the program increasing social stability and supports.

There were many limitations based on inconsistencies with the data. Consequently, there were several implications for policy and practice. There are many current research studies regarding sex offender treatment in general, but there was a lack of research specifically relating *The Road to Freedom* program, as well as specifically relating to the Sex Offender Treatment Intervention and Progress Scale (SOTIPS). More research is needed in this area.

Program Analysis of an Adult Sex Offender (ASO) Treatment Group

A Thesis

Presented to

The Faculty of the Graduate School of Social Work

Abilene Christian University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Science

In Social Work

By

Danielle Day

May 2016

This thesis is dedicated to my wonderful husband, Caleb Day, who has been my biggest fan from the beginning; I am also dedicating this thesis to my parents, Mark and Pam Todd, who continued to push me to do my best, even when I wanted to give up.

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## CHAPTER I

### INTRODUCTION

Treatment of sexual offenders, within criminal policy and among professionals in the mental health field, is a very controversial and complicated topic (Bradford, Fedoroff, & Gulati, 2013; Lösel & Schmucker, 2005). In the media, sex offenders are commonly portrayed as being untreatable, repeat offenders (Bradford et al., 2013). Sexual misconduct is difficult to treat because it is considered to be both a private and a public offense; consequently, it affects both the individuals involved, and the local community (Roseman, Yeager, Korcuska, & Cromly, 2008). Because sexual offending is a social problem that fuels public outrage, correction and treatment policies and practices emphasize supervision of offenders to prevent revictimization (Mann, Webster, Wakeling, & Keylock, 2013; McGrath, Cumming, Hoke, & Bonn-Miller, 2007). This emphasis results in prioritization of risk-assessment and risk-reduction strategies and calls for development of, and utilization of, accurate risk-assessment measures (McGrath, Lasher, & Cumming, 2012).

Currently, The Center for Child and Family Advocacy utilizes a sex offender treatment program titled *The Road to Freedom*, written by Morin and Levenson (2002). This specific program utilizes a cognitive behavioral approach combined with elements of a risk-needs-responsivity model, a positive future orientation, and a strong emphasis on relapse prevention. This study will help inform the Center for Child and Family

Advocacy about the degree to which this program is effective at reducing risk factors for reoffending.

CHAPTER II  
LITERATURE REVIEW  
**History of Intervention**

**Past Interventions**

Throughout the years, there have been a variety of responses toward the subject of sexual violence. The field of sex offender treatment was first influenced by the women's movement, which first realized that sexual victimization was a major social problem needing solutions (Hanson, 2014). One such solution, correctional rehabilitation, provides goals and methods of treatment aiming to reintegrate offenders into society as law-abiding citizens (Hanson, 2014). Many early rehabilitation models had a behavioral orientation and focused on decreasing deviant sexual arousal with the hopes of eliminating deviant sexual behaviors (Stinson, Becker, & McVay, 2015). However, recent research indicates that only a minority of offenders demonstrates deviant sexual arousal (Stinson et al., 2015).

In the mid-1990s, sexual crimes and questions regarding treatment of offenders gained the attention of media, court systems, politicians, families, and treatment providers (Braithwaite, 2015). The question of appropriate strategies to protect the public from recidivistic sexual offenses committed by known sex offenders became a major public concern that has driven the trend toward registration and notification policies (Braithwaite, 2015; Zgoba & Levenson, 2012). An emphasis was placed on punishment of sexual offenders. However, now there is evidence available that demonstrates the

potential effectiveness of treatment for sexual offenders (Hanson et al., 2002; Lösel & Schmucker, 2005).

### **Current Interventions**

Since the 1990s, there has been an increase in instituted policies addressing the punishment, management, tracking, and rehabilitation of sex offenders (Levenson & D'Amora, 2005; Zgoba & Levenson, 2012). The public oftentimes seems to view sex offender treatment from a punishment perspective, while treatment professionals tend to view sex offender treatment from a rehabilitative perspective (Mann & Barnett, 2012). Many of these policies are used in combination to promote community safety and decrease repeat sex crimes, as well as help rehabilitation become more effective; some of the specific policies instituted are civil commitment, registration, mandatory community-based treatment, residence restriction, and community notification statutes (Levenson, 2011; Levenson & D'Amora, 2005; Mercado, Alvarez, & Levenson, 2008; Zgoba & Levenson, 2012).

The current driving force for gaining knowledge in the area of treatment of sexual offenders is the movement for practices that are evidence-based (Hanson, 2014). Current policy and practice pertaining to those convicted of sexual crimes reflects a belief that participation in community-based programs should be mandatory (Aytes, Olsen, Zakrajsek, Murray, & Ireson, 2001). Such programs often stipulate that treatment last for two to three years, especially for those convicted of a felony or a misdemeanor sexual offense (Aytes et al., 2001). Several studies found that the recidivism rates of those sex offenders participating in treatment were lower than the recidivism rates of those sex

offenders who did not participate in treatment (Hanson et al., 2002; Lösel & Schmucker, 2005).

### **Therapeutic Methods**

It is essential that treatment of sexual offenders be done in such a way that the results are positive and constructive (Marshall et al., 2005). Much debate currently exists regarding research and practice. Such debates often concern issues such as whether treatment models should emphasize public safety (risk-management) or individual rehabilitation (Ward, 2007). Because sexual offenders are spending less time incarcerated, and more time receiving community treatment, the need for effective and efficient outpatient treatment has continued to increase significantly (Collins, Brown, & Lennings, 2010). Other strongly voiced opposing views include whether treatment programs utilizing treatment manuals are preferable, or more effective, than individually-tailored psychotherapy (Mann, 2009; Ward, 2007). Lastly, there is concern regarding the degree to which treatment programs should adhere to evidence-based methods of treatment (Ward, 2007).

### **Good Lives Model**

This particular theoretical framework has recently begun to be used more frequently in adult sex offender treatment programs throughout North America (Willis, Ward, & Levenson, 2014). The major purpose of this model is to encourage risk reduction while also teaching sex offenders the tools they need to live meaningful and healthy post-treatment lives. While using this model, facilitators focus on increasing hope, helping participants create approach goals, creating an environment in which participants work collaboratively, and enhancing self-esteem (Marshall et al., 2005;

Willis et al., 2014) In order for this approach to be effective, therapists must encourage their clients to identify which needs the clients are attempting to meet through illegal sexual behavior. The next step is then to aid the clients in creating goals regarding how to meet their needs through healthy and socially acceptable behavior (Marshall et al., 2005).

Some research suggests that this particular model could increase the effectiveness of programs being run from a risk-need-responsivity model, because focusing solely on risk can increase the potential for overly confrontational therapeutic methods and a lack of rapport among group members and clinicians (Marshall et al., 2005; Willis et al., 2014). In a study comparing the good lives model with a conventional risk-reduction and relapse-prevention program, there were no significant differences in attrition rates or rates of treatment change (Harkins, Flak, Beech, & Woodhams, 2012). In addition, post-treatment interviews with 17 participants and 11 facilitators were conducted. In general, the authors concluded that interviewees believed the good lives model had more of a positive (defined as what is possible—as opposed to what not to do) focus than the relapse prevention model.

### **Risk-Need-Responsivity Model**

This specific model focuses primarily on working to rehabilitate sexual offenders, through the use of risk management, in order to avoid harming the community (Marshall et al., 2005). There are three major principles that are essential to the model. The *risk principle* states that higher level of intervention should correlate directly with higher levels of risk of re-offending (Ward, 2007). The *need principle* suggests that, in order to eliminate recidivism completely, the focus of therapy should be on the variables associated with lower rates of recidivism (Ward, 2007). The *responsivity principle*

proposes that treatment programs should be adapted to fit each offender's learning style, level of motivation, and personal and interpersonal situations (Ward, 2007).

The core values that are emphasized through this approach include community protection, efficient treatment delivery, personal awareness of risk, and personal rights of victims (Ward, 2007). One of the major criticisms of this model is that it could imply that there is more emphasis on momentary management of illegal sexual behavior (risk management), instead of focusing on improving the quality of life for the individual sexual offender (Marshall et al., 2005). It is important to note that utilizing the risk-need-responsivity model could prove to be more effective than other methods of treatment, yet there is not a significant amount of research available regarding the effectiveness of methods used to treat sexual offenders in general (Hanson, 2014; Hanson, Bourgon, Helmus, & Hodgeson, 2009).

### **Trauma-Informed Care**

A study utilizing a sample of 679 male sexual offenders found that sex offenders are three times more likely to have been sexually abused as a child, two times as likely to have been physically abused, 13 times more likely to have been verbally abused, and four times more likely to have come from a broken home or experienced emotional neglect (Levenson, Willis, & Prescott, 2014). Many persons convicted of sexual offenses against children report having been abused themselves during their childhood, correlating with the high number of mental health and antisocial behavior displayed by the sexual offenders (Aslan & Edelmann, 2014). Research suggests that relational approaches to therapy, such as trauma-informed care, can enhance the interpersonal skills and general well-being of the client population (Levenson, 2014).

According to Bloom & Farragher (2013) and Harris, McHugo, Fallot, & Xie (2011), this particular service delivery should incorporate emphasis on the prevalence and impact that early trauma can have on behavior occurring throughout the duration of the lifespan; problems throughout the lifespan can include attachment, self-regulation, and relational competence (as cited in Levenson, 2014; Levenson et al., 2014). This approach to therapy can be utilized within the context of cognitive-behavioral therapy, the good lives model, or the risk-needs-responsivity model (Levenson, 2014).

### **Cognitive-Behavioral Therapy**

While there are many different intervention approaches that are used in treatment of sexual offenders, recent research seems to suggest that comprehensive cognitive-behavioral approaches may lead to lower rates of recidivism, especially when combined with relapse prevention approaches (Aytes et al., 2001; Heaton & Murphy, 2013; Lösel & Schmucker, 2005; Sandhu & Rose, 2012). Additionally, there is evidence that manualized cognitive-behavioral therapy treatments are more likely to achieve higher rates of attendance, fewer program dropouts, and less non-compliance (Craissati, South, & Bierer, 2009).

In a study conducted by Aytes and colleagues (2001), those sex offenders who completed a cognitive-behavioral treatment group had lower rates of recidivism than those offenders who did not complete treatment. When the re-offense rates were compared between the counties, with one receiving treatment and the other having no treatment, it was found that recidivism was reduced by over 40 percent (Aytes et al., 2001). Another study suggests that utilizing a cognitive-behavioral model reduced sexual recidivism rates from 17.4% to 9%; the general recidivism rates dropped from 51% to



32% (Hanson et al, 2002). Additionally, offenders participating in a program that was a year or longer, were less likely to reoffend than those participating in shorter treatment programs (Aytes et al., 2001).

Treatment from a cognitive-behavioral perspective generally utilizes a teaching method in which clients are given information that they are required to apply to their own lives and situations (Bauman & Kopp, 2006). There are some essential components that are included within the treatment setting. In order to effectively address the offenses, the offenders must focus on identifying cognitive distortions and changing attitudes towards sex offenses (Sakdalan & Gupta, 2014). Aytes and colleagues (2001) also emphasize the importance of teaching offenders to identify and manage their personal deviant arousal patterns, as well as provide internal barriers to continue with healthy behavior following the completion of a treatment program.

Some of the more specific issues with self-regulation can include general/affective, interpersonal, and sexual dysregulation (Sakdalan & Gupta, 2014). Throughout the entirety of cognitive-behavioral treatment, relapse prevention skills must be taught and utilized by the sex offenders (Aytes et al., 2001; Sakdalan & Gupta, 2014). Each of these issues contributes to a higher risk of recidivism if not thoroughly addressed within the treatment environment (Sakdalan & Gupta, 2014).

### **Group Therapy**

Creating a successful treatment program for sex offenders has major implications for communities, as well as individual sex offenders, because it has become a specialized topic presenting with many challenges (Clarke, 2011; Harkins et al., 2012). As of 1997, nearly 140,000 sex offenders were under the control of correctional agencies, while being

supervised within the community (McGrath, Cumming, & Holt, 2002). While many interventions have been utilized with the sex offender population, group therapy is currently the preferred treatment method being used within prisons and within the community (Jennings & Sawyer, 2003).

One of the most prominent reasons why group therapy is often used is because it involves all group members, which creates a social and relational aspect that is essential to the function of the group (Jennings & Sawyer, 2003). The results of a study by Garrett, Oliver, Wilcox, & Middleton (2003) found that, overall, sexual offenders found that their group treatment was a positive experience. The main reason for this is because a majority of the offenders felt that their understanding of their offending behavior was enhanced. Some of the important aspects of group treatment include identifying thoughts and behaviors that may be impeding on motivation for change, providing open and responsible accountability to peers, and gaining interpersonal understanding leading to growth and development of each individual (Frost, Ware, & Boer, 2009).

### **Role of the Therapist**

In general, the research regarding effectiveness of treatment programs has focused more on the treatment theories, instead of on the therapeutic processes used to deliver those theories (Sandhu & Rose, 2012). It is very important that therapists providing treatment to those convicted of a sexual offense find a difficult balance between demonstrating empathy towards the clients, while also maintaining professional boundaries during the entirety of the treatment process (Collins et al., 2010). The practitioner's use of therapeutic processes must be evident on the group level, as well as on the individual level, in order to be most effective during treatment (Frost et al., 2009).

## **Therapeutic Factors**

A study by Marshall, Marshall, Fernandez, Malcolm, & Moulden (2008) discussed that utilizing a motivational approach within treatment, alongside several therapeutic approaches, could help create a more effective method of treatment. Additionally, the therapeutic factors of therapeutic relationship and program objectives were related to engagement in therapy, but the topic has not been researched much with this specific population (Holdsworth, Bowen, Brown, & Howat, 2014). There is a body of evidence that proves that clients have more positive outcomes when they feel bonded to their therapists, especially when both the client and the therapist agree upon the goals and methods of treatment (Leibert & Dunne-Bryant, 2015). When the therapeutic factors encourage engagement in therapy, the group members are more likely to develop healthy coping skills, increase in perspective taking, and improve in their interpersonal relationship skills (Ware & Bright, 2008). It is important that training for group therapists be available that helps to ensure a positive approach is used with group members, through viewing the therapeutic alliance as a dynamic process that must continue to grow and deepen (Garrett et al., 2003; Leibert & Dunne-Bryant, 2015).

## **Therapist Techniques**

Several of the most important aspects of group therapy include the techniques of the therapist, the clients' view of the therapist's techniques, the therapeutic alliance between therapist and clients, and the therapeutic climate present within the group treatment (Marshall & Burton, 2010). According to Drapeau (2005), the clients appreciated the therapists for specific qualities, including honesty, respectfulness, empathy, warmth, nonjudgmental stance, caring nature, and availability. Additionally, it

is essential that therapists respect the client's right to self-determination and autonomy (Levenson, 2011; Marshall et al., 2005). According to Ware and Bright (2008), the use of appropriate body language, open-ended questions, tone of voice, optimal length of therapist's talking, and encouragement of participation also increased effectiveness of treatment. Each of these qualities is compatible with utilizing motivational interviewing, in addition to a cognitive-behavioral and or relapse prevention approach, because each quality helps grow the therapeutic approaches that interact with those models (Bauman & Kopp, 2006).

The use of aggressively confrontational styles of therapy has demonstrated to be detrimental in the effectiveness of adult sex offender therapy groups (Ware & Bright, 2008). Additionally, having lower interest in the offender and obvious hostility has also been found to hinder how effective the treatment (Ware & Bright, 2008).

### **Therapist Gender**

According to a study completed by Sandhu and Rose (2012), there is limited evidence that the gender of the therapist may have some impact on the therapeutic process with sex offenders. Some research found that program participants felt equally comfortable with female or male therapists (Garrett, Oliver, Wilcox, & Middleton, 2003). Other research suggests that when adult male offenders have a female therapist, there could be more potential change in offender perceptions, attitudes, and relationships with women in their personal lives (Sandhu & Rose, 2012).

### **Readiness for Treatment**

Many theories propose that there are various external and internal factors that may encourage or discourage offenders from being ready to engage in treatment (Mann et al.,

2013). While there is a limited amount of research available regarding the need of readiness for treatment for those convicted of sexual offenses, there is no denying the importance of readiness for treatment for other populations. This alone argues the need for researchers to fully evaluate client readiness to change as a predictor of treatment success with sexual offenders. In expressing readiness for treatment, clients either utilize change talk, which includes specific statements arguing for change talk, or sustain talk, which include statements in opposition to change (Osilla et al., 2015).

According to the Treatment Readiness Scale created by Serin, Mailloux, and Kennedy (2007), there are eight major factors that must be considered: problem recognition, benefits of treatment, treatment interest, treatment distress, treatment goals, treatment behaviors, motivational consistency, and treatment support (as cited in Brown & Tully, 2014). A study conducted by Levenson & Macgowan (2004) demonstrated that there is a strong correlation between engagement in group therapy and treatment progress. It is essential that the therapist encourage the use of change talk, and minimize the use of sustain talk; this is even more important in a group treatment setting with manualized treatments that the therapist needs to learn (Osilla et al., 2015). Likewise, it was also shown that there is a strong inverse relationship between denial of need for treatment and treatment progress; this demonstrates why there can oftentimes be a great amount of variance in treatment progress among those convicted of sexual offenses (Levenson & Macgowan, 2004).

### **Internal Factors**

Research by Holdsworth and colleagues (2014) found that the psychosocial factors of hostility and impulsivity predicted low engagement levels in treatment.

However, anger and anxiety seemed to have little effect on engagement (Holdsworth et al., 2014). There are four major disclosure management, or engagement, styles that can be seen in adult sex offender treatment groups, including exploratory, oppositional, evasive, and placatory (Frost, 2004). The only engagement style that has proven to be favorable within the treatment setting is the exploratory style (Frost, 2004). When working with sex offender treatment groups, the emphasis on creating victim empathy helps to enable group members to understand and feel remorse over the harm that has been caused to the victims, in order to develop greater cognitive flexibility in situations encountered in the future (Mann & Barnett, 2012).

### **Treatment Refusal**

Around 50 percent of those convicted of a sexual offense in prison and community agencies refuse to participate in the available sex offender treatment programs (Brown & Tully, 2014). Based on qualitative and quantitative research, those who refused treatment tended to be less aware of the positive outcomes of treatment, as well as reported more negative effects of treatment seen in others (Mann et al., 2013). Those who refused treatment were more likely to report feeling pressured to take part in the programs, as well as more likely to report feeling that the program is not relevant to the situation (Brown & Tully, 2014).

Not only does non-participation in treatment correlate with higher risks for reoffending, it also correlates with non-cooperative and antisocial personalities (Grady, Howe, & Beneke, 2013; Hanson et al., 2002). However, Levenson (2011) states that while lower levels of minimization and more personal accountability appear to increase

therapeutic engagement, and potentially lower recidivism rates, it cannot be assumed that there is a causal link between denial and recidivism.

### **Rural Offenses**

It is important to examine rural offenses because all clients at The Center for Child and Family Advocacy are considered to be rural clients. Rural offenses, in particular, must be studied because of the potential structural variables (i.e. isolation, high levels of poverty, and uses of formal and informal social control) found in these communities that differ from those found in urban offenses (Braithwaite, 2015). In a research study conducted by Braithwaite (2015), it was found that sex offenses occurring in the home were largely impacted by resource disadvantage, which combines poverty, family disruption, unemployment, and high school drop-out rates, and local investment, which combines home ownership and residential stability, in urban communities.

One such resource deprivation is the lack of education among those convicted of a contact sexual offense; only four percent of contact offenders reported graduating from a university with a postgraduate degree (Aslan & Edelmann, 2014). However, in rural communities, some of these variables did not significantly impact the rates of sexual offenses occurring in rural homes, indicating a need for continued research (Braithwaite, 2015). Additionally, local investment did significantly predict the rates of sexual crimes occurring outside the home within rural communities but not urban communities; this is evident in the higher number of sex crimes occurring in unmonitored places (Braithwaite, 2015).

Additionally, a separate study conducted by Mann, Hanson, and Thornton (2010) suggests that, oftentimes, convicted sex offenders are forced to live in areas with fewer

employment opportunities. Public policies that deter sex offenders from becoming employed could be continuing to encourage criminal persistence, instead of acting as a deterrent as intended (Mercado et al., 2008). Sixty-four percent of contact, or physical offenses, and 63% of internet-contact (i.e. pornography distribution, sexting, etc.) offenders were unemployed at the time that the sexual offense occurred (Aslan & Edelmann, 2014). Additionally, sex offenders forced to live in rural areas have fewer social ties and limited access to treatment programs (Mann et al, 2010). Each of these reasons increases the likelihood of recidivism rates (Mann et al., 2010).

Other than these few studies, there is a great need for more research specifically addressing the presence of sexual crimes in rural areas. According to the Uniform Crime Report (UCR), there was a general decline in total crimes in urban counties from 1987 to 2009. However, total crimes in rural counties during this time remained steady, instead of decreasing (Deller & Deller, 2011). General research on rural crimes demonstrates that crimes may be underreported in rural areas, as compared to urban areas (Chilenski, Syvertsen, & Greenberg, 2015). According to a study by Wells and Weisheit (2004), moving from urban communities to rural communities showed a decrease in ability to accurately predict crime rates. More specifically, there is evidence that economic risk, as discussed previously, could be one of the strongest predictors of overall crime in rural communities (Chilenski et al., 2015).

Overall, there seems to be a vast amount of recent literature on the subject of sex offender treatment. However, there is a lack of research specifically addressing *The Road to Freedom* program. The limited literature that does exist seems to suggest that it is a very effective program. Additionally, the literature confirms that it is essential for sex



offender treatment programs to include elements of the good lives model, risk-needs-responsivity model, trauma-informed care, and cognitive behavioral therapy. Along with these methods of therapy, it is essential to examine the elements necessary for effective group therapy. There is no negating that the role of the therapist is also essential to an effective program. This includes positive therapeutic factors, therapist techniques, and therapist gender. Readiness for treatment, including internal factors and treatment refusal, must be examined because these aspects will also impact whether or not a treatment is considered to be effective. Lastly, when examining the effectiveness of a program, the setting, such as rural or urban, must be given some consideration. Some programs may be more or less effective depending on the client population. In summary, each of these subjects play important parts in understanding the effectiveness of adult male sex offender treatment groups.

## CHAPTER III

### METHODOLOGY

The purpose of this experimental study was to understand if The Center for Child and Family Advocacy's adult sex offender group is effective at lowering risk responsibility and criminality; and increasing treatment cooperation, self-management, and social stability and supports; in a sample of males required by law to participate in sex offender rehabilitation. A paired-samples *t*-test was used to compare initial scores (first measurement) from the Sex Offender Treatment Intervention and Progress Scale (SOTIPS), with scores, on the same instrument measured while in treatment (second measurement).

#### **Treatment**

The treatment material that is currently being used for the adult sex offender group is *The Road to Freedom*, by Morin and Levenson (2002). This particular program is a comprehensive and semi-structured program that utilizes a cognitive-behavioral model of treatment (Levenson, Macgowan, Morin, & Cotter, 2015). However, there are also elements of the good lives model, the risk-needs-responsivity model, and trauma-informed care that are included in the program material.

The intervention provides psychoeducational information to the clients so that they have the freedom to apply the information to their own situation (Levenson et al., 2015). Each group member begins working through the manual upon joining, and continues working through the program material in the order that it appears in the

program book. The chapters are titled as follows: (1) accepting responsibility, (2) understanding your behavior, (3) managing your behavior, (4) understanding yourself, (5) victim impact, (6) relationship and communication skills, (7) thinking, feeling, behaving, and (8) relapse prevention (Morin & Levenson, 2002). This treatment group meets weekly, for approximately an hour and a half. Consequently, most of the clients remain in treatment for a year or two (Levenson et al., 2015).

### **Study Participants**

The participants in this study were convicted sexual offenders living in or near the Four County area in Northwest Ohio. These counties include Defiance, Fulton, Henry, and Williams, all of which are considered to be rural communities. The participants each were court mandated to the sex offender treatment group that The Center of Child and Family Advocacy provided. It is essential to note that the length of treatment varies for each client. Length of treatment is determined by how quickly or slowly the client completes the program material.

### **Data**

This study used pre-existing data collected by the agency. All identifying information was removed before the data were stored and analyzed. Therefore, informed consent was not necessary for each client participating in the sex offender treatment group. This study was approved, however, by the Abilene Christian University Institutional Review Board (see Appendix A). There was a sample size of 13 for those clients who had completed treatment (closed clients), and a sample size of 12 for those clients who are currently in treatment.

## Measurement

The Sex Offender Treatment Intervention and Progress Scale (SOTIPS), seen in Appendix B, is a provider-administered evaluation form consisting of 16 scale-rating questions. The purpose of the scale is to examine the risk factors among adult male sex offenders that are completing treatment (Lasher, McGrath, Wilson, & Cumming, 2015; McGrath et al., 2012). The assessment is given every 6 months, beginning with intake, in order to help measure progress within the program (Lasher et al., 2015; McGrath et al., 2012). A 4-point Likert scale is used to assign a rating to each of the 16 scale items. The Likert scale ranges from *minimal to no need for improvement* (i.e., a rating of 1) to *very considerable need for improvement* (i.e., a rating of 4) (Lasher et al., 2015; McGrath et al., 2012). McGrath and Cumming (2001, 2003) demonstrated that the 16 items chosen for the final version of the SOTIPS scale, showed a statistically significant relationship to sexual recidivism (as cited in McGrath et al., 2012). Present evidence suggests that when therapists and clients complete a SOTIPS form, there is moderate inter-rater agreement in dynamic risk, as well as in treatment goals overall (Lasher et al., 2015).

According to *The Sex Offender Treatment Intervention and Progress Scale (SOTIPS) Manual* (McGrath, Cumming, & Lasher, 2013), this evaluation form is reliable ( $ICC = .77, p < .001$ ), and has moderate predictive validity for violent ( $AUC = .66, p < .001$ ) and other sexual ( $AUC = .74, p < .001$ ) offending behaviors (as cited in Lasher et al., 2015). Additionally, in a study conducted utilizing four co-therapists who completed different SOTIPS forms, the interrater reliability ( $ICC = .89, p < .001$ ) showed strong overall agreement (Lasher et al., 2015).

### **Design and Data Collection Methods**

This study used a quantitative repeated measures approach to evaluate the effectiveness of The Center of Child and Family Advocacy's methods of treatment for adult sex offenders. The outcome measure (i.e., SOTIPS) was completed before treatment and at every 6-month interval. In most cases, data was collected by the therapist leading the group. Because this study is of an agency program that was already in operation for years before the study began, the researcher had no control over data collection. In some cases, therefore, pre-intervention data was missing, or data sheets failed to indicate whether a measurement occurred before treatment began or sometime after treatment began. The researcher, therefore, coded the earliest measurement simply as measurement 1. Additionally, because of specifications given from the IRB, no demographic information was allowed to be used in this study or seen by the researcher, including names and dates.

### **Data Analysis**

To analyze data to determine if a statistically significant relationship exists between length of time spent in treatment and improvement on the SOTIPS scale, scores for each SOTIPS measurement were entered into a computer program (e.g., SPSS). A linear, repeated-measures model was used to test for change over time on the dependent variable (i.e., SOTIPS score). As is the convention in social research, the probability of making a type I error (i.e.,  $\alpha$ ) was set at .05.

## CHAPTER IV

### RESULTS

#### **Completed Clients**

The research question being addressed through the study is whether or not the adult sex offender group is effective in lowering risk responsibility and criminality, and increasing treatment cooperation, self-management, and social stability and supports. To determine if this is the case, the differences between the first measurement and second measurement of SOTIPS scores will be examined. Table 1 presents the results of the paired-samples *t*-tests for clients who completed the program. As the table shows, the difference between the total pretest and posttest mean SOTIPS scores was statistically significant. A mean difference between pretest and posttest of 15 indicates significant improvement. Inspection of individual questions showed that all questions, with the exception of item 15 (residence), showed a statistically significant decline on the SOTIPS item mean score. Item number 1 (sexual offense responsibility) demonstrated the largest change in the mean value (i.e., 1.46). Items 1 (sexual offense responsibility), 5 (sexual risk management), 6 (criminal and rule-breaking behavior), 8 (stage of change), 12 (problem solving), 13 (impulsivity), 14 (employment), and 16 (social influence) all declined by a value of one or more. Clients who have completed the program in this sample failed to demonstrate improvement on the other SOTIPS items.

Table 1

*Paired-Samples t-Test Statistics for Completed Clients*

Comparison	$\Delta$ Mean	SD	SE	95% CI		$t(12)$	$p$
				Lower	Upper		
Q1Pre - Q1Post	1.46	0.66	0.18	1.06	1.86	7.98	0.00
Q2Pre - Q2Post	0.77	0.93	0.26	0.21	1.33	2.99	0.01
Q3Pre - Q3Post	0.92	0.95	0.27	0.35	1.50	3.49	0.00
Q4Pre - Q4Post	1.00	1.29	0.36	0.22	1.78	2.79	0.02
Q5Pre - Q5Post	1.23	1.01	0.28	0.62	1.84	4.38	0.00
Q6Pre - Q6Post	1.00	0.71	0.20	0.57	1.43	5.10	0.00
Q7Pre - Q7Post	0.69	1.03	0.29	0.07	1.32	2.42	0.03
Q8Pre - Q8Post	1.00	0.82	0.23	0.51	1.49	4.42	0.00
Q9Pre - Q9Post	0.92	1.04	0.29	0.30	1.55	3.21	0.01
Q10Pre - Q10Post	0.92	1.04	0.29	0.30	1.55	3.21	0.01
Q11Pre - Q11Post	0.54	1.05	0.29	-0.10	1.17	1.85	0.09
Q12Pre - Q12Post	1.31	0.95	0.26	0.74	1.88	4.98	0.00
Q13Pre - Q13Post	1.23	0.73	0.20	0.79	1.67	6.12	0.00
Q14Pre - Q14Post	1.31	1.44	0.40	0.44	2.18	3.28	0.01
Q15Pre - Q15Post	0.15	1.57	0.44	-0.80	1.10	0.35	0.73
Q16Pre - Q16Post	1.00	1.16	0.32	0.30	1.70	3.12	0.01
Total Pretest Score - Total Posttest Score	15.00	8.38	2.32	9.94	20.06	6.46	0.00

**Current Clients**

Table 2 presents the paired-samples  $t$ -test results for current clients. Once again, results show that a significant improvement occurred from pretest to posttest on the total SOTIPS mean score. Not surprisingly, the mean pre- to post-test difference was smaller for current clients than for completed clients. Additionally, as compared to completed clients, more item scores on the SOTIPS posttest were not statistically different from the scores on the SOTIPS pretest. Items not showing a statistically significant pre-post-test difference included items 8 (stage of change), 9 (cooperation with treatment), 12 (problem solving), and 16 (social influences).

Table 2

*Paired-Samples t-Test for Current Clients*

Comparison	Mean	SD	SE	95% CI		<i>t</i> (11)	<i>p</i>
				Lower	Upper		
Q1Pre - Q1Post	0.92	1.17	0.34	0.18	1.66	2.73	0.02
Q2Pre - Q2Post	0.67	0.99	0.28	0.04	1.29	2.35	0.04
Q3Pre - Q3Post	0.67	1.16	0.33	-0.07	1.40	2.00	0.07
Q4Pre - Q4Post	0.75	1.36	0.39	-0.11	1.61	1.92	0.08
Q5Pre - Q5Post	1.08	1.08	0.31	0.40	1.77	3.46	0.01
Q6Pre - Q6Post	1.17	1.34	0.39	0.32	2.02	3.02	0.01
Q7Pre - Q7Post	0.67	1.23	0.36	-0.12	1.45	1.88	0.09
Q8Pre - Q8Post	0.33	1.37	0.40	-0.54	1.20	0.84	0.42
Q9Pre - Q9Post	0.25	1.14	0.33	-0.47	0.97	0.76	0.46
Q10Pre - Q10Post	0.58	1.08	0.31	-0.11	1.27	1.87	0.09
Q11Pre - Q11Post	0.33	1.23	0.36	-0.45	1.12	0.94	0.37
Q12Pre - Q12Post	0.50	1.00	0.29	-0.14	1.14	1.73	0.11
Q13Pre - Q13Post	1.08	1.24	0.36	0.30	1.87	3.03	0.01
Q14Pre - Q14Post	1.08	1.78	0.51	-0.05	2.22	2.11	0.06
Q15Pre - Q15Post	0.67	1.07	0.31	-0.02	1.35	2.15	0.05
Q16Pre - Q16Post	-0.17	1.19	0.35	-0.93	0.59	-0.48	0.64
Total Pretest - Total Posttest	9.42	13.77	3.98	0.67	18.17	2.37	0.04

**All Clients**

Unsurprisingly, combining data for completed and current clients yields overall results showing significant improvement in the SOTIPS total score as well as on the majority of individual items, as seen in Table 3. Interestingly, no significant change was observed on either item 15 (residence) or item 16 (social influences). Item 1 (sexual offense responsibility) and 14 (employment) showed the most improvement, while items 14 (employment), 5 (sexual risk management), 13 (impulsivity), and 6 (criminal and rule-breaking behavior) (in descending order) all showed mean differences of 1 or more.



Table 3

*Paired-Samples t-Test Results for Completed and Current Clients*

Comparison	Mean	SD	SE	95% CI		<i>t</i> (23)	<i>p</i>
				Lower	Upper		
Q1Pre - Q1Post	1.20	0.96	0.19	0.81	1.60	6.27	0.00
Q2Pre - Q2Post	0.72	0.94	0.19	0.33	1.11	3.85	0.00
Q3Pre - Q3Post	0.80	1.04	0.21	0.37	1.23	3.84	0.00
Q4Pre - Q4Post	0.88	1.30	0.26	0.34	1.42	3.38	0.00
Q5Pre - Q5Post	1.16	1.03	0.21	0.74	1.58	5.64	0.00
Q6Pre - Q6Post	1.08	1.04	0.21	0.65	1.51	5.20	0.00
Q7Pre - Q7Post	0.68	1.11	0.22	0.22	1.14	3.07	0.01
Q8Pre - Q8Post	0.68	1.15	0.23	0.21	1.15	2.97	0.01
Q9Pre - Q9Post	0.60	1.12	0.22	0.14	1.06	2.68	0.01
Q10Pre - Q10Post	0.76	1.05	0.21	0.33	1.19	3.61	0.00
Q11Pre - Q11Post	0.44	1.12	0.22	-0.02	0.90	1.96	0.06
Q12Pre - Q12Post	0.92	1.04	0.21	0.49	1.35	4.43	0.00
Q13Pre - Q13Post	1.16	0.99	0.20	0.75	1.57	5.88	0.00
Q14Pre - Q14Post	1.20	1.58	0.32	0.55	1.85	3.80	0.00
Q15Pre - Q15Post	0.40	1.35	0.27	-0.16	0.96	1.48	0.15
Q16Pre - Q16Post	0.44	1.29	0.26	-0.09	0.97	1.70	0.10
Total Pretest - Total Posttest	12.32	11.41	2.28	7.61	17.03	5.40	0.00

Overall, it is evident that The Center for Child and Family Advocacy's adult sex offender group is effective in lowering risk responsibility and criminality for current client, completed clients, and total clients. The program is also effective in increasing treatment cooperation and self-management in each of the three client groups. However, the program effectiveness in increasing social stability and supports is fairly effective in clients who have completed, but not statistically significant in client still in treatment or in the total client population.

## CHAPTER V

### DISCUSSION

The findings of this study suggest that *The Road to Freedom* workbook is an effective intervention for male individuals who have committed sexual offenses. Risk factors for sexual offending, measured using SOTIPS, significantly decreased between the initial and the final measurement. The reduction in these factors is most likely due to replacing old coping skills with new, safer coping skills. Theoretically, reduction of these variables decreases the likelihood for re-offending.

Inspection of individual SOTIPS items indicates that this program is effective in aiding adult sex offenders in improving the 16 different topics that are measured in the SOTIPS form. For those clients who have already completed the treatment program, item 15 (residence) was the only item that was found not to be statistically significant. While the therapists do encourage clients to improve their housing situations when necessary, this question is largely outside the control of the therapists. All other questions, as well as the total scores, showed statistically significant change, based on a 95% confidence interval.

With clients who are currently involved in treatment, five questions had no statistically significant change from the first measurement to the second measurement: question 8 (stage of change), question 9 (cooperation with treatment), question 11 (emotion management), question 12 (problem solving), and question 16 (social influences). However, it is important to note that these results are based on clients who

have not yet completed treatment. Therefore, it would be unrealistic to expect that these clients would have statistically significant changes in all questions, seeing as they are still developing the skills necessary to avoid reoffending. The total SOTIPS scores did have a statistically significant change in the first measurement as compared to the second measurement. Even though these clients have not experienced the full benefits of treatment, it is evident that the program is still effective in helping them develop greater coping skills.

When the results were combined, the only questions that did not have statistically significant improvements were question 15 (residence), and question 16 (social influences). While these two questions do pertain to the topic of social stability and supports, and seem to warrant some speculation, these items, by themselves do not predict recidivism. Even though improvement in social ability and supports contained limited data supporting it, there is concrete evidence that the program is effective in lowering risk responsibility and criminality; and, at increasing treatment cooperation and self-management in all three groups. Overall, it is evident that this program, as a whole, is very effective in rehabilitating adult male sex offenders.

### **Limitations**

There are many limitations that are evident in this study. Because no control group was used, it is not possible to rule out threats to internal validity (Rubin & Babbie, 2011). The extent to which the intervention was responsible for the changes in SOTIPS scores, versus other plausible explanations, is, therefore, unknown. Numerous other variables (e.g., additional psycho-education, individual psychotherapy, group counseling, and 12-Step meetings) could contribute to improvement. Additionally, historical events,

changes in social-environmental factors, maturation, regression toward the mean, and other unknown factors could have contributed to the results. Without a control group, it was impossible to control for such extraneous variables.

Another limitation is the small sample size. Because of inconsistencies regarding the completion of the SOTIPS form, there were very few clients who actually had both a pre-test and a post-test completed by therapists in the agency. This is important to note because a larger sample size would provide more consistent and accurate results regarding correlation and significance.

A third limitation is that the researcher could not access the research in the files, based on the request of the IRB committee. Instead, the researcher had a coworker gather the data and delete identifying information, such as names and dates. This could cause a limitation because the researcher was not able to personally ensure that the data were accurately collected.

A fourth limitation is that some of therapists did not fill out the SOTIPS forms completely. This is important because not answering one of the 16 questions would affect the total scores. Additionally, not reporting how many months in weekly treatment the client has completed makes it difficult to analyze how differences in time in treatment might affect the total scores.

A fifth limitation is that there were 10 different therapists that filled out this form for clients. Additionally, the pre-test is usually completed by a different therapist, who completed the intake assessment for the client, than the post-test that is completed by the therapist that is providing the treatment. By encouraging the same therapist to complete

both the pre-test and the post-test SOTIPS forms, there could potentially be greater reliability and validity of the scoring.

Lastly, in the data collected, there were four different versions being utilized by therapists (2003, 2008, 2012, and 2013). Because each version of the form is different, the researcher only examined the 16 questions that were common among all four versions, as well as the adjusted total scores for those 16 items only. By utilizing consistent versions of the SOTIPS form, the potential for human error could be decreased.

### **Implications for Policy and Practice**

It would be highly beneficial for The Center for Child and Family Advocacy to move toward using the most recent (2013) version of the SOTIPS form. This could help in ensuring that the scores are truly comparable in the future. Additionally, the therapists that are completing the SOTIPS forms need to ensure that the entirety of the form is being filled out, including the number of months the client has been in weekly treatment. By doing so, future research could be completed to better understand which of the 16 topics areas are being successfully addressed, and whether the time the SOTIPS was completed correlates with the apparent success of the program.

### **Implications for Future Research**

One area for future research would be to find a method of allowing the clients to self-report, in each of these 16 areas. The self-reports could then be compared to the therapists' reports of those areas. This would be a good way to better understand the reliability and the validity of the therapists' view of the clients' monthly progress in adult sex offender treatment.

A second area for future research is more research about well the program *The Road to Freedom* directly addresses the areas measured on the SOTIPS form. There is little to no current data existing about the relationship between this treatment and this measurement method. If there are areas on the SOTIPS that are not addressed well enough in the program, such as residence, then it would be important to add a section to the program that addresses that issue.

Lastly, it would be interesting to complete further research on how well the SOTIPS form is connected to actual recidivism rates. There is very limited research examining if there is a causal relationship between the two. If this could be expanded on in the future, it could help agencies advocate further for rehabilitation of the sex offender population.

In conclusion, it is evident that The Center for Child and Family Advocacy's adult male sex offender group is effective in lowering risk responsibility and criminality, and increasing treatment cooperation and self-management. Additionally, there is some limited evidence that the program may be helpful in increasing social stability and supports. If some of these other areas for research can be addressed in the future, it would be beneficial in providing a greater understanding of the direct relationship between specific treatment programs and measurement tools, as well as provide information on if there is a causal relationship between scores on specific measurement tools and actual rates of recidivism.

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APPENDIX A  
IRB APPROVAL LETTER

**ABILENE CHRISTIAN UNIVERSITY**

*Educating Students for Christian Service and Leadership Throughout the World*

Office of Research and Sponsored Programs  
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103  
325-674-2885



01/27/2016

Danielle Day  
Department of Social Work  
325 E. Bryan St. Bryan, OH 43506  
Abilene Christian University

Dear Ms. Day,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled Program Analysis of an Adult Sex Offender Treatment Group

(IRB# 16-007 )is exempt from review under Federal Policy for the Protection of Human Subjects as:

- ☐ Non-research (45 CFR 46.102(d))
- ☒ Non-human research (45 CFR 46.102(f))

Based on:

Investigator is receiving anonymous, de-identified data.

The investigator and the holder of the key have entered into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

*Megan Roth*

Megan Roth, Ph.D.  
Director of Research and Sponsored Programs



## APPENDIX B

### SOTIPS

#### Sex Offender Treatment Intervention and Progress Scale (SOTIPS)

**Individual:** \_\_\_\_\_ **Scorer:** \_\_\_\_\_  
**Evaluation Date:** \_\_\_\_\_ **Setting:** ☐ Community ☐ Residential  
**Months in Weekly Treatment:** \_\_\_\_\_ **Time of Evaluation:** ☐ Initial  
**Months in Aftercare Treatment:** \_\_\_\_\_ ☐ During Treatment  
**Total:** \_\_\_\_\_ ☐ End of Treatment

**Rating Guide** (use definitions in scoring manual):

0 = minimal or no need for improvement  
 1 = some need for improvement  
 2 = considerable need for improvement  
 3 = very considerable need for improvement

<b>Sexuality and Risk Responsibility</b>	0	1	2	3
1. Sexual Offense Responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual Attitudes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sexual Interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sexual Risk Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Criminality</b>	0	1	2	3
6. Criminal and Rule-Breaking Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Criminal and Rule-Breaking Attitudes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Treatment and Supervision Cooperation</b>	0	1	2	3
8. Stage of Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Cooperation with Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Cooperation with Community Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Self-Management</b>	0	1	2	3
11. Emotion Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Social Stability and Supports</b>	0	1	2	3
14. Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Residence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Social Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sub-totals</b>				
<b>Total</b>				

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